STATE OF MAINE

BOARD OF PHARMACY

APPLICATION FOR PHARMACIST LICENSURE by Reciprocity

All applicants must take the Maine Multistate Pharmacy Jurisprudence Examination

Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8620
TTY/Hearing Impaired (207) 624-8563
Fax: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: kelly.l.mclaughlin@maine.gov

Published under appropriation 01402A4380012 Revised 04/01/05
Physical address: 122 Northern Ave, Gardiner Maine 04345
Website: www.maineprofessionalreg.org

APPLICATION INSTRUCTIONS

LICENSURE BY RECIPROCITY

THE FOLLOWING IS INCLUDED IN THIS PACKET
(Please contact this office if any of these items are missing):

- ☐ NABP Preliminary Application for Transfer of Pharmaceutic Licensure™
- ☐ Maine Board of Pharmacy application for licensure
- ☐ NAPLEX/MPJE Registration Bulletin - www.nabp.net
- ☐ Information to prepare for the Multi-state Pharmacy Jurisprudence Exam
- ☐ Credit card authorization form
- ☐ Accommodation request form (Americans with Disabilities Act)

THE FOLLOWING IS THE APPLICATION PROCEDURE:

- Complete the NABP Preliminary Application for Transfer of Pharmaceutic Licensure™ as instructed.

- Complete the Multi-state Pharmacy Jurisprudence Examination registration form (included in the Registration Bulletin) and submit directly to National Association Boards of Pharmacy (NABP), PO Box 1057, Park Ridge, IL 60068. The fee for the MPJE is $170.00 (payment must be made in the form of a certified bank check or money order and made payable to NABP) NOTE: NABP will NOT accept personal checks or credit card payments.

- The Maine Board of Pharmacy requires an examination application fee of $100.00, reciprocity fee of$150.00 and a $15.00 fee for the criminal history record check. Total due: $265.00 payable to Treasurer, State of Maine (VISA or MasterCard are accepted– see credit card authorization form).

- Once the completed NABP Preliminary Application for Transfer of Pharmaceutic Licensure™ and the completed Maine Board of Pharmacy application for licensure is received at the Board office. Please allow 7 to 10 days for processing.

- Your MPJE score result is reported directly by electronic means to the Maine Board, which will be reported to you in writing.

- A Foreign pharmacy graduate must submit the FPGEC issued by NABP with this application.

- Recent passport size photograph.

If you have a disability and may require some accommodation in taking this examination, be sure to fill out and submit the enclosed "request for accommodation" form along with this application. If accommodation is not requested in advance, we cannot guarantee the availability of accommodation on-site.

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The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted. Documents that have been modified or altered in any way will not be accepted.

MULTISTATE PHARMACY JURISPRUDENCE EXAM PREPARATION

In preparing for the Maine portion of the multistate pharmacy jurisprudence exam, you must be familiar with the Maine Pharmacy Act 32 MRSA, Board Rules, and Title 21 of the Code of Federal Regulations (CFR) Part 1300 to end. If you need a copy of CFR Part 1300 to end, please contact the following:

U.S. Government Printing Office
Telephone: (202) 512-1800

Or you can access this information at the following web site:

www.access.gpo.gov/nara/cfr/cfr-table-search.html

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AND FINANCIAL REGULATION
BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE BY RECPROCITY

Reciprocity Fee:	**$150.00**
Application for Examination Fee:	**$100.00**
Criminal History Record Check Fee:	**$ 15.00**
TOTAL FEE DUE:	***$265.00***

Please Make Check Payable to Treasurer, State of Maine
or completed credit card authorization form

Complete the following in ink (type or print):

Name:		
Any other names used:		
Contact Address:		
City:	State:	Zip Code:
County:	Telephone #:	
Social Security #:	Date of Birth:	
Email address:		

Employment (drug stores only):

Dates: From _____To _____

From _____To _____

From _____To _____

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College of Pharmacy: _____

Date of graduation: _____

Date of high school graduation: _____

Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

Have you ever:

Been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your DEA Registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? ☐Yes ☐No

Have any state or territory of the U.S., province/territory of Canada, or any other jurisdiction EVER denied your application for any type of examination, professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? ☐Yes ☐No

Been indicted, arrested or convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐Yes ☐No
If yes, please describe below in detail the crime(s), list dates(s), and submit a copy of the court judgements(s) as well as a letter from you explaining the circumstances surrounding your conviction.

Been disciplined by a professional society? ☐Yes ☐No

LIST BELOW EVERY STATE IN WHICH YOU HAVE EVER HELD OR CURRENTLY HOLD A LICENSE:

STATE, TERRITORY, COUNTRY	LIC/REG NUMBER	DATE ISSUED	EXPIRATION DATE

ATTACH A SEPARATE PIECE OF PAPER 8½" by 11" IF ADDITIONAL SPACE IS NEEDED

*You must also send the enclosed Verification of Licensure form to any other state board where you hold or have held a license. Please follow directions on the form.

Criminal History Record Checks

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be $15.00 as of May 1, 2003.

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

By submitting this application and supporting documents I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Applicant's signature:_____

Date:_____

CERTIFICATE OF GOOD MORAL CHARACTER AND TEMPERATE HABITS

This certificate of good moral character and temperate habits must be furnished and signed by a person of good standing in the community in which he or she resides.

Date:_____

To the Board of Pharmacy:

I, _____of_____,
(printed name) (city/town)
county of_____, state of _____,

being duly sworn, do say upon oath that _____,

the applicant herein named, has been personally known to me for _____ years, last past, that my acquaintance with him/her throughout that period has been sufficient to afford me ample opportunity to become fully informed as to his/her moral character and temperate habits, that he/she is not addicted to the use of alcoholic liquors or narcotic drugs so as to render him/her unfit to practice pharmacy, that he/she is of good moral character and that I recommend him/her so far as his/her character and habits are concerned, as worthy to be licensed to practice pharmacy in Maine.

Signature_____

Occupation_____

Address_____

_____

By submitting this application and supporting documents I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

_____ _____
SIGNATURE OF APPLICANT DATE

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VERIFICATION OF LICENSURE

THIS FORM MUST BE COMPLETED BY THE STATE LICENSING AGENCY

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary.)

Applicant
Name:_____

Contact
Address:_____

_____
(state) (zip code)

License #:_____ Date Issued:_____

I hereby authorize the Board of Pharmacy of the State of _____ to furnish to the Maine State Board of Pharmacy the information requested below.

Applicant Signature: Date:

To be completed by the State Licensing Board verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named was issued:
License # Date issued Date of expiration

_____

Current Status of License: (check all that apply)□Active □Inactive □Lapsed
□Probation □Restricted □Suspended □Revoked

Disciplinary Action: (If yes, please attach a copy of the decision and a detailed explanation for the discipline and a copy of the consent agreement(s) or decision & order(s) issued)

Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation? □Yes □No

Signature:_____

Title:_____

State completing this form: _____

Date: _____

(SEAL)

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DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ **in the amount of: $**_____

Signature: _____**Date:** _____/_____/_____

PHONE: (207)624-8620
(Office Phone)

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

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ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will note be shared with any outside source without your express written permission

Name: _____

Address: _____

Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.

Disability _____

Please check all that apply

- ❑ **Accessible Testing Site**
- ❑ **Separate Testing Site**
- ❑ **Braille**
- ❑ **Large Print**
- ❑ **Tape**
- ❑ **Reader as Accommodation for Visual Impairment**
- ❑ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ❑ **Reader as Accommodation for Learning Disability**
- ❑ **Scribe/Amanuensis as Accommodation for Learning**
- ❑ **Sign Language Interpreter**
- ❑ **Extended Time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More than double time (specify)** _____
- ❑ **Use of Computer or Other Adaptive Equipment (specify)** _____
- ❑ **Other:**

  _____

Signed and Dated: _____

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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disability condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a

(Test applicant) **(date)**

_____

(professional title)

The applicant has discussed with me the nature of the test to be administrated. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following:
(check all types)

- ❑ **Taped test**
- ❑ **Large print test**
- ❑ **Reader**
- ❑ **Scribe/amanuensis**
- ❑ **Extended time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More that double time (please justify)**

    _____
- ❑ **Separate Testing Area**
- ❑ **Use of Computer or Other Adaptive Equipment (please specify)**

  _____
- ❑ **Other (please specify)**

  _____

Signed: _____ **Title:** _____

Date: _____ **License # (**If applicable**):**_____

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